

City of Rio Rancho Department of Financial Services - Ambulance Billing Authorization for Release of Medical Records

Please complete all the information on this form as completely and accurately as possible by typing or using blue or black ink. Please contact us at (505) 891-5010 with any questions.

Section I - Patie	ent Information	Date of	Birth:	
Patient Name:	Look Name	First Name	MI	SSN:
	Last Name	FIRST Name	141	
Section II - Info	ormation to be Ro	eleased		
Medical Records F	rom (date):	То	(date):	
Reason for Releas	se of Records:			
Patient Limits the	Release of the Fol	lowing Information:		
	f treatment by the	igned authorizes the City of Rio Rancho t	•	to release any and all
Address:		ist name		
Street			City/State	Zip
Phone #:	F	ax #:	E-Mail: _	_
authorization by pro Services/Ambulance E receipt of the written insurer with the right authorization. (3) I h disclosed pursuant to by federal privacy rul	viding a written noting a written noting a written revocation. The revocation are revocation of the contest a claim. (2) have a right to inspect the authorization may es. (4) Authorizing the significant revocation of the context of the significant revocation of the context of	ce of revocation to the will not apply to inform ocation will not apply to it?) The City of Rio Rancho and receive a copy of the be subject to re-disclosue disclosure of this health	City of Rio Rancho ation that has already my insurance company will not condition treate material to be disclosive by the recipient and information is volunta	e the right to revoke this - Department of Financial been released prior to the when the law provides my ment on whether I sign this ed. The information used or may no longer be protected ry and I may refuse to sign this authorization is as valid
Patient Signatur	re:			
(or legally authori				Date
Witnessed By:				Date

Please return this completed and signed form to: Attn: Steve Perkins, Ambulance Billing, 3200 Civic Center Circle NE, Rio Rancho, NM 87144 - or fax to: (505) 891-5762